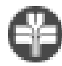
Obesity Consult Center



Tufts- New England Medical Center

750 Washington Street, NEMC #900
Boston, MA 02111
Phone: 617-636-0158
Fax: 617-636-2386
www.obesityconsult.org

DATE____________________

Name___________________________________ Social Security # ______-_____-______

Address ____
street city state zip code

Telephone: home (____)__________________ work (____)________________

E-mail address ___________________________ Fax (____)________________

Sex____ Date of birth ____/____/____ Marital status_____ Number of children _____

How did you hear about our program?____

Reason for referral ____

____

Your occupation ____

Place of employment____

Current weight or best estimate_________ Current height or best estimate__________

If you are unsure at this point about the program you want, you may check more than one:
Physician-supervised/Behavioral Program ❑ Surgical Programs: Bypass ❑ Lap-Band: ❑

People currently living in your household

Name	Age	Relationship
________________________________	_________	_________________
________________________________	_________	_________________
________________________________	_________	_________________
________________________________	_________	_________________

Health Care Providers - Medical

Primary Care Physician ____

Address____

Telephone (____) ____________________ Fax (____) ______________________

Health Care Providers – Mental Health

Therapist or Mental Health Counselor ____

Address ____

Telephone (____) ____________________ Fax (____) ____________________

Psychopharmacologist ____

Address ____

Telephone (______) ___________________________ Fax (____) __________________________

Please list all other medical specialists and healthcare providers. If you need more space, list additional providers' names, specialties, addresses, and telephone and fax numbers on the back of this page.

Provider Name_______________________________________ Specialty_____________

Address ____

Telephone (____) ___________________ Fax (____) ____________________

Provider Name_______________________________________ Specialty_____________

Address ____

Telephone (____) ___________________ Fax (____) ____________________

Pharmacy name ____

Pharmacy address ____

Telephone (____) ___________________ Fax (____) ____________________

Alcohol, Tobacco, and Nonprescription Drug History

Current Use. List all alcohol, tobacco, and nonprescription drugs that you currently use and the amounts that you use. List any additional products on the back of this page.

	Type of Product	Amount per day	How often do you use this substance? Per Day	Per Week
Alcohol	____________	________	______	______
	____________	________	______	______
Tobacco	____________	________	______	______
	____________	________	______	______
Drugs	____________	________	______	______
	____________	________	______	______

Past Use. List products you have used in the past, how often and for how long, and the approximate date of last use.

	Type of Product	How often did you use this substance?	How long did you use this substance?	When did you stop using this substance?
Alcohol	____________	________	________	________
	____________	________	________	________
Tobacco	____________	________	________	________
	____________	________	________	________
Drugs	____________	________	________	________
	____________	________	________	________
	____________	________	________	________

Family History

Please check any of the following conditions that your parents, your siblings, or your children have ever experienced.

_______ Obesity

_______ Diabetes

_______ Heart disease

_______ High cholesterol or triglycerides

_______ Cancer type(s) ______________________________

Prescription Medications, Supplements, and Remedies

Please list all your current medications, supplements, and remedies. If you need additional space, please continue on the back of this page.

Prescription drugs and doses (including psychiatric medications and birth control)

Over the counter drugs

Vitamins/supplements/herbal remedies

Allergies to prescription medication(s)

Hospitalizations

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment. If you need additional room, please continue on the back of this page.

Approximate Date	Problem	Hospital

Medical History

Please check each of the following conditions that you are experiencing now, or have experienced in the past. List any additional conditions.

	Heart and Circulation	Comments
________	Chest pain/coronary artery disease/angina	________
________	Congestive heart failure	________
________	Irregular or rapid heart beat (arrhythmias)	________
________	Peripheral vascular disease	________
________	Leg swelling (edema)	________
________	Hypertension/high blood pressure	________
________	Stroke	________
________	Blood clots	________
________	Other: ________	________

	Lungs	Comments
________	Shortness of breath	________
	___at rest ___walking on flat ground ___on stairs/hills	________
________	Asthma	________
________	COPD (emphysema, chronic bronchitis)	________
________	Pulmonary embolism (blood clot in the lungs)	________
________	Sleep apnea _____C-PAP settings _________	________
________	Other: ________	________

	Endocrine	Comments
________	Diabetes	________
________	High cholesterol, high triglycerides	________
________	Infertility	________
________	Menstrual irregularities	________
________	Thyroid _____Hypothyroidism (underactive)	________
	_____Hyperthyroidism (overactive)	________
________	Excessive hot or cold feeling	________
________	Visual changes	________
________	Change in voice	________
________	Recent increase in thirst or urination	________
________	Abnormal hair growth	________
________	Abnormal menstrual periods	________
________	Numbness or tingling in hands or feet	________
________	Other: ________	________

Gastrointestinal/GI	Comments
________ Gastroesophageal Reflux (GERD)	________
________ Heartburn	________
________ Ulcers	________
________ Crohn's Disease, Ulcerative Colitis	________
________ Frequent diarrhea	________
________ Frequent constipation	________
________ Gallbladder ____gallstones ____gallbladder removed	________
________ Fatty liver	________
________ Colon ____hemorrhoids ____ polyps	________
________ Liver ____hepatitis ____ cirrhosis	________
________ Other: ________________	________

Blood	Comments
________ Anemia	________
________ Iron deficiency	________
________ Other: ________________	________

Musculoskeletal	Comments
________ Back pain	________
________ Arthritis type: ________________	________
Other:	

Psychiatric	Comments
________ Depression	________
________ Bipolar disorder	________
________ Eating disorder _____anorexia _____bulimia	________
________ Other: ________________	________

Other	Comments
________ Kidney disease	________
________ Kidney stones	________
________ Other: ________________	________
________ Other: ________________	________

Weight and Weight Loss History

Weight 1 year ago______________ Estimated daily calorie intake _______________

Are you at your highest weight ever? Yes __________ no _________

If you answered ‘no’, what was you highest weight? ______ lbs. When? ___________

Please fill in all previous weight loss methods that you have tried. List any additional methods.

Dietary Intervention	# Wks/Months Attempted	Pounds Lost	Length of Time Sustained Wt Loss
Weight Watchers			
Jenny Craig			
Nutrisystem			
Diet Center			
Diet Workshop			
LA Weight Loss			
TOPS			
Atkins			
South Beach Diet			
OA			
HMR			
Optifast			
Medifast			
Phentermine (Fastin, Adipex)			
Redux (Dexfenfluramine)			
Pondimin (fenfluramine)			
Fen-Phen			
Meridia (Sibutramine)			
Xenical (Orlistat)			
Dexetrim			
Metabolife			
Trimspa			
Ephedra (Ma Huang)			
Slimfast			
Hypnosis			
Acupuncture			
Nutritionist			
Behavioral Therapy			
Other:			

At each age below, circle the best description of how heavy you were in comparison to your peers.
Age 5: obese heavy average below average
Age 10 obese heavy average below average
Age 15 obese heavy average below average
Age 20 obese heavy average below average

How much do you expect to lose as a result of treatment at the Obesity Consult Center?
___Less than 50 lbs. ___50-100 lbs. ___100-150 lbs. ___more than 150 lbs.

Weight, Social and Mood History

Please read the list of problems and complaints below. On each line, fill in the number from the scale below which best describes how much that problem has bothered or distressed your during the past week, including today.

Not at all	A little bit	Moderately	Quite a bit	Extremely
0	1	2	3	4

______ 1. Nervousness or shakiness inside.
______ 2. Unwanted thoughts, words or ideas that won’t leave your thoughts
______ 3. The idea that someone else can control your thoughts
______ 4. Feeling others are to blame for most of your troubles
______ 5. Trouble remembering things
______ 6. Feeling easily annoyed or irritated
______ 7. Feeling afraid in open space or on the street
______ 8. Thoughts of ending your life
______ 9. Hearing voices that other people do not hear
______ 10. Feeling that most people cannot be trusted
______ 11. Crying easily
______ 12. Feeling of being trapped or caught
______ 13. Suddenly scared for no reason
______ 14. Temper outbursts that you could not control
______ 15. Feeling afraid to go out of your house alone
______ 16. Feeling blue
______ 17. Worrying too much about things
______ 18. Feeling fearful
______ 19. Other people being aware of your private thoughts
______ 20. Feeling afraid to travel on buses, subways or trains
______ 21. Having to avoid certain things, places or activities because they frighten you
______ 22. Your mind going blank
______ 23. Feeling hopeless about the future
______ 24. Trouble connecting
______ 25. Having thoughts that are not your own
______ 26. Having urges to beat, injure, or harm someone
______ 27. Having urges to break or smash things
______ 28. Having ideas or beliefs that others do not share
______ 29. Spells of terror or panic
______ 30. Getting into frequent arguments
______ 31. Feeling nervous when you are left alone
______ 32. Feeling so restless that you could not sit still
______ 33. Feelings of worthlessness
______ 34. Feeling that familiar things are strange or unreal
______ 35. Shouting or throwing things
______ 36. The idea that you should be punished for your sins
______ 37. The idea that something is wrong with your mind

The Obesity Consult Center has my permission to release information to:

Name____

Street Address____

City, State, Zip____

Name____

Street Address____

City, State, Zip____

Insurance Information

Please complete all that apply.

Insurance Co. Name: _______ ID #: __________

Insurance Company Address: ____________________

Named Insured: ____________________ Soc. Sec. # ____________________

Relationship to patient: ____ self ____ spouse ____ child ____ other

We'd like to know a little more about you. Any hobbies you have, things you enjoy doing and can't anymore because of your weight, concerns and questions about the programs here, etc.

____

I have carefully read all the materials in this Assessment and have answered the questions as truthfully as possible.

____________________ signature ____________________ date